# Is the declaration of Alma Ata still relevant to primary health care?

Thirty years after WHO highlighted the importance of primary health care in tackling health inequality in every country, **Stephen Gillam** reflects on the reasons for slow progress and the implications for today's health systems

After years of relative neglect, the World Health Organization has recently given strategic prominence to the development of primary health care. This year sees the 30th anniversary of the declaration of Alma Ata (box 1). Convened by WHO and the United Nations Children's Fund (Unicef), the Alma Ata conference drew representatives from 134 countries, 67 international organisations, and many non-governmental organisations. (China was notably absent.) Primary health care "based on practical, scientifically sound and socially acceptable methods and technology made universally accessible through people's full participation and at a cost that the community and country can afford" was to be the key to delivering health for all by the year 2000.1 Primary health care in this context includes both primary medical care and activities tackling determinants of ill health.

In the polarised world of the cold war, the declaration inevitably reflected political and semantic compromises. Nevertheless, its ambition resonated powerfully with a generation of leftward leaning doctors, plying their trade in what is often regarded as a golden age for general practice in the United Kingdom. Sentimental celebration of the anniversary alone has little meaning for later generations, but the visions still have relevance today.

## **Primary health care eclipsed**

Early efforts at expanding primary health care in the late 1970s and early 1980s were overtaken in many parts of the developing world by economic crisis, sharp reductions in public spending, political instability, and emerging disease. The social and political goals of Alma Ata provoked early ideological opposition and were never fully embraced in market oriented, capitalist countries. Hospitals retained their disproportionate share of local health economies.

In many health systems, a medical model of primary care dominated by professional vested interests resisted the expansion of community health workers with less training. Such programmes anyway proved difficult to sustain, and little empirical research existed to justify them. Many international agencies sought early, tangible results rather than the fundamental, political changes implied by the original concept of primary health care. Selective primary health care and packages of low cost interventions such as GOBI-FFF (growth monitoring, oral rehydration, breast feeding, immunisation; female education, family spacing, food supplements) in some respects distorted the spirit of Alma Ata.<sup>2</sup> The failure in

**Editorial** by De Maeseneer et al

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sjg67@medschl.cam.ac.uk Accepted: 14 January 2008 most countries to provide even limited packages, coupled with the proliferation of vertical initiatives to tackle specific global health problems, hastened its eclipse.

Geographic and financial inaccessibility, limited resources, erratic drug supply, and shortages of equipment and staff have left many countries' primary care services disappointingly limited in their range, coverage, and impact. Primary health care was hardly mentioned in the millennium declaration.<sup>3</sup>

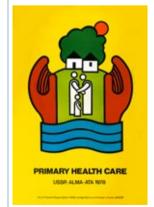
## **Challenges facing health systems**

Low and middle income countries, like high income ones, face an increasing prevalence of non-communicable illness. This shift has already led to the coexistence of persisting infectious disease, undernutrition, and reproductive health problems alongside emerging non-communicable disease and related risk factors (such as smoking, hypertension, obesity, diabetes, stroke, and cardiovascular disease). This epidemiological transition poses considerable challenges to health systems. Most systems are oriented to maternal and child health and the care of acute, episodic illness. Primary healthcare services appropriate to future needs will have to be able to deliver effective management of chronic disease.

At the halfway stage, progress towards the millennium development goals is least impressive where the neediest populations live, notably in sub-Saharan Africa. Global initiatives tackling priority diseases like AIDS, tuberculosis, and malaria may undermine broader health services through duplication of effort, distortion of national health plans and budgets, and particularly through diversion of scarce trained staff. Holistic care is often neglected in favour of the technicalities of controlling disease.

Ironically, Alma Ata highlighted the limitations of top-down, single issue programmes. Primary health care and the horizontal integration of health programmes are integral to attainment of the millennium development goals. For example, efforts to integrate preventive chemotherapy programmes targeting five of the so called neglected tropical diseases are projected to result in cost savings of up to 47%.

Primary health care is also the key interface linking, on the one hand, ambulatory care with hospital and specialty services and, on the other, individual clinical care with community-wide health, nutrition, and family planning programmes. Failure to recognise the inter-relationship between components of a district health system has resulted in great inefficiency. In low income countries this first level of care could deal with up to 90% of



The declaration of Alma Ata helped to entrench the idea of health care as a human right demands. Evidence suggests that health systems that are oriented towards primary health care are more likely to deliver better health outcomes and greater public satisfaction at lower costs.<sup>10</sup> No single system of primary health care can be universally applicable. 11 A major challenge is to establish the most effective combinations of interventions that can target multiple conditions and risk factors affecting key groups (children, women, and older adults, for example) and that are appropriately adapted to local epidemiological, economic, and sociocultural contexts. Clustering of interventions can achieve comprehensiveness despite resource constraints. Such clusters are likely to include the integrated management of childhood illnesses; maternal and reproductive health services; clinic and community based management of tuberculosis, HIV and AIDS, and other sexually transmitted infections; management of malaria; management of hypertension and other cardiovascular risk factors, stroke, and cardiovascular disease; mental illness and substance misuse.<sup>12</sup>

Not only does primary care constitute the first point of patient or family contact, it is also a critical base for extending care to communities and vulnerable groups. Outreach services may focus on individual preventive measures (such as immunisation, vitamin A, or oral rehydration therapy) or community-wide health promotion (such as education on child nutrition or adult diet and exercise). These services depend substantially on community support and mechanisms for identifying, training, and supporting village or community health workers.  $^{13\ 14}$  However, the empirical evidence on large scale and routine primary healthcare programmes is scant. There is plenty of evidence for cost effective interventions that could vastly improve maternal and child health, 15 for example, but less evidence on how to ensure these services reach the most vulnerable populations to lasting effect<sup>16</sup>—and without the detrimental concomitants of vertical approaches. A community focused operational research agenda has been neglected in favour of research on individual interventions. Evaluations of new ways of organising primary healthcare services in specific settings are required. Such research is complex because it is context specific and dependent on local capacity and commitment. Translation of the evidence into coherent, operational strategies at district level and below will be an equally big challenge.

Affordability remains the over-riding and universal challenge. What services can realistically be provided free at the first point of contact and what mix of financing mechanisms should be promoted to do so? The place of user charges for primary health care remains contested for they have repeatedly been shown to deter those most likely to benefit from preventive activities. <sup>17</sup> Indeed, one way to reach poorer people is to provide them with financial incentives to visit services.

Many countries are piloting schemes that give money or vouchers to increase access to particular services such as maternity care.<sup>18 19</sup> Other ways to improve equitable access include monitoring delivery of service and health outcomes in separate population groups and provision of incentives to service providers to deliver services to vulnerable groups.<sup>20</sup> The reality in low and middle income



Alma Ata 30 years ago: this year's anniversary provides a salutary reminder of what is at risk

#### Box 1 | Characteristics of primary health care from Alma Ata declaration1

- Evolves from the economic conditions and sociocultural and political characteristics of a country and its communities
- Is based on the application of social, biomedical, and health services research and public health experience
- Tackles the main health problems in the community—providing promotion, preventive, curative, and rehabilitative services as appropriate
- Includes education on prevailing health problems; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunisation against the main infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs
- Involves all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, and industry
- Requires maximum community and individual self-reliance and participation in the planning, organisation, operation, and control of services
- Develops the ability of communities to participate through education
- Should be sustained by integrated, functional, and mutually supportive referral systems, leading to better comprehensive health care for all, giving priority to those most in need
- Relies on health workers, including physicians, nurses, midwives, auxiliaries, and community workers as well as traditional practitioners, trained to work as a team and respond to community's expressed health needs

# Box 2 | Essential components of effective primary health care

- Well trained, multidisciplinary workforce
- Properly equipped and maintained premises
- Appropriate technology, including essential drugs
- Capacity to offer comprehensive preventive and curative services at community level
- Institutionalised systems of quality assurance
- Sound management and governance systems
- Sustainable funding streams aiming at universal coverage
- Functional information management and technology
- Community participation in the planning and evaluation of services provided
- Collaboration across different sectors—for example, education, agriculture
- Continuity of care
- Equitable distribution of resources

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countries is that most primary medical care will continue to be provided by private and non-governmental organisations. How can independent providers be encouraged to deliver centrally determined priorities? (The UK's quasi-independent general practitioners provide some instructive experience.)

Many places, and particularly sub-Saharan Africa, have crippling shortfalls in human resources, partly as a result of international and internal migration; hence the renewed interest in the possible contribution of community workers. Ironically, poor countries that emulated training standards in industrialised countries have been most vulnerable to poaching by them. <sup>21</sup> One of the greatest challenges is to overcome the loss of motivation and sense of resignation of many primary healthcare workers who work in understaffed settings. They lack consistent managerial support and have grown accustomed to a norm of inadequate service. <sup>22</sup>

In most developing countries jobs in primary health care are regarded as low status, and are less valued than those in hospital medicine by both the public and policymakers. Only high level political commitment and adequate governance and funding will raise the status of primary care and attract suitable workers. Various bodies have recently proposed that 15% of the budgets of disease oriented programmes be invested in strengthening primary healthcare systems by 2015 ("15 by 2015").<sup>23</sup>

#### **Past and future threats**

Many industrialised countries have extensively improved their primary tiers, influenced to varying degrees by Alma Ata. For others, including the UK, the rhetoric of Alma Ata was of mostly symbolic importance. Pivotal turning points in the postwar development of general practice—notably the Family Doctor Charter of 1966-were already yielding benefits. The UK already boasted some of the best primary medical care in the developed world. British general practice has been one of the main reasons for the relative efficiency of the National Health Service. But moves under the current Labour government to create a market for these services threaten to fragment health care and erode the public support that holds the NHS together.<sup>24</sup> Experience from North America suggests that dividing the care of chronic diseases between different commercial companies principally concerned to increase profit margins results in less efficient and more inequitable care.<sup>25</sup>

Effective primary health care is more than a simple summation of individual technological interventions (box 2). Its power resides in linking different sectors and disciplines, integrating different elements of disease management, stressing early prevention, and the maintenance of health. A patient centred approach—a striking feature of family medicine in northern European countries but barely reflected in the medical curriculums of most developing countries—strives to tailor interventions to individual need. <sup>26</sup> On the other hand, the concept of the empowered consumer engaged in shared decision making is far from what was implied by the term community participation. Health professionals can be supported and rewarded for roles that promote social mobilisation.

#### **SUMMARY POINTS**

The declaration of Alma Ata defined primary health care 30 years ago Although it had huge symbolic importance, its effect in practice was more limited

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Community participation and intersectoral action remain challenges for those working to reduce health inequalities
The changing global burden of disease and workforce shortages make effective integration of existing vertical programmes essential
Primary health care is key to providing good value for money and enhancing equity

Alma Ata remains relevant for effective healthcare systems today

Support for intersectoral action should come from ministerial level downwards.

Health systems are part of the fabric of social and civic life. <sup>27</sup> They both signal and enforce societal norms and values through the personal experiences of providers and users. The declaration of Alma Ata helped to entrench the idea of health care as a human right. This anniversary provides a salutary reminder of what we are placing at risk.

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